

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/12/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS REGIONAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E 17TH ST COLUMBUS, IN 47201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN00100329 Unsubstantiated: lack of sufficient evidence</p> <p>Date of survey: 4-12-12</p> <p>Facility number: 005099</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Columbus Regional Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules.</p> <p>QA: cloughlin 05/01/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1